MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161C

10313

Reg. Dist. No. 254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Grasonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne's
City or town: Grasonville - Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: /

3.(a) FULL NAME Katherine Albee Blunt

3.(b) Social Security Number /

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Nov 6 - 1947

8. AGE: Years | Months | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Grasonville - Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Charles H. Blunt
13. Birthplace: Grasonville

MOTHER
14. Maiden name: Flora Virginia Albee
15. Birthplace: Talbot - Md

16. Informant: Chas. H. Blunt
Address: Grasonville Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: Nov 25/47 (month) (day) (year)
Cemetery or crematory: Perry's Corner
Location: Perry's Corner

18. Funeral director: Barton Bros.
Address: Centreville - Md

19. Nov. 24 1947 (Date rec'd by registrar) Helen M. Aldridge Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 1947, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1947, to Nov 23 1947
and that I last saw h...e alive on Nov 22 1947

Immediate cause of death	DURATION
Gastro-enteritis and Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William C. Crane MD
M. D. or other
Address: Queenstown Md Date signed: Nov 24, 47

RECEIVED
DEC 4 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10314

CERTIFICATE OF DEATH

Reg. Diat. No. 913

1. PLACE OF DEATH:

County: Queen Anne

City or town: Rural Stevensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Rural Stevensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edward John Bower

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Katherine Bower

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): October 19, 1864

8. AGE: Years: 83 Months: 1 Days: 9 If less than one day: hrs. min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)

10. Usual occupation: Attendance Officer

11. Industry or business: Board of Education

FATHER

12. Name: John Bower

13. Birthplace: Philadelphia, Pa.

MOTHER

14. Maiden name:

15. Birthplace:

16. Informant: Mrs. Katherine Bower

Address: Stevensville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/2/47 (month) (day) (year)

Cemetery or crematory: Hillside Cemetery

Location: Roslyn, Pa.

18. Funeral director: Edgar L. Kane

Address: Church Hill, Md.

19. Dec 3 1947 (Date rec'd by registrar) Elizabeth Hopkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28 1947 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23 1947, to November 27 1947

and that I last saw him alive on November 27 1947

Immediate cause of death	DURATION
Pneumonia, lobar, left lower	6 days
Due to	
Due to	
Other conditions: Arteriosclerosis, generalized; Cataracts, bilateral	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William C. Kane, MD (M. D. or other)

Address: Queenstown, Md. Date signed: Nov 28, 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 4 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166 10315

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:
County: Queen Anne
City or town: Narrows - Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Grasonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME John Maylvee Cooper

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife: Elizabeth Wilson Cooper
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Feby 6 - 1920

8. AGE: Years 27 | Months 8 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Grasonville - Md. (Town, county, and state)
10. Usual occupation: Lastmaker
11. Industry or business

FATHER
12. Name: Thomas R. Cooper
13. Birthplace: Grasonville

MOTHER
14. Maiden name: Lettie Gertrude Butler
15. Birthplace: Baltimore

16. Informant: Lettie Gertrude Cooper
Address: Grasonville

17. Burial, cremation, or removal. Which? Burial Date thereof: Nov 4-47 (month) (day) (year)
Cemetery or crematory: Bethel Church Cemetery
Location: Grasonville - Md

18. Funeral director: Carter Bros
Address: Centreville, Md

19. Nov. 4 19 47 Helen M. Aldridge
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 - 19 47 at 11-15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shot in abdomen — hemorrhage & Shock	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 11-1-47
Where did injury occur? Narrows-Qa - Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Shot in abdomen Injured at work?

23. SIGNATURE: W. Henry Fisher
Dept. Med. Examiner Q.A.C.
M. D. or other
Address: Centreville Md Date signed: 11-4-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1947
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10316

CERTIFICATE OF DEATH

Reg. Diat. No. 253

1. PLACE OF DEATH:

County: Queen Anne

City or town: Rural Chester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 1/2 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Rural Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Fannie Tilghman Cornish

3.(b) Social Security Number: 220-09-1316

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Married

6.(b) Name of husband or wife: Nehemiah E. Cornish

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): April 7, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	7	5		

9. Birthplace: Easton Maryland (Town, county, and state)

10. Usual occupation: Oyster Shucker

11. Industry or business: Oyster

FATHER — 12. Name: Richard Tilghman

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: Margaret (Unknown)

MOTHER — 15. Birthplace:

16. Informant: Nehemiah E. Cornish

Address: Rural Chester, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/16/47 (month) (day) (year)

Cemetery or crematory: Cambridge Md.

Location:

18. Funeral director: Leon H. Henry

Address: 310 South St. Easton Md

19. NOV-16 1947 Elizabeth Hopkins (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 12 1947 at 2:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7 1947, to November 11 1947

and that I last saw her alive on November 11 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 dys.
Due to: Hypertension	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William C. Crowe MD (M. D. or other)

Address: Queenstown Md Date signed: 11-12-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 20 1917
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 10317 2 13

1. PLACE OF DEATH:

County: Queen Anne's

City or town: Stevensville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Q. A.

City or town: Stevensville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William R. Cray

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: /

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 7-1880

8. AGE: Years	Months	Days	If less than one day
67			..... hrs. ..... min.

9. Birthplace: Q. A. Co. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

FATHER — 12. Name: James F. Cray

13. Birthplace: Q. A. Co.

MOTHER — 14. Maiden name: Nora Dicker

15. Birthplace: Talbot Co.

16. Informant: Mrs Catherine Ewing

Address: Stevensville Md

17. Burial (Burial, cremation, or removal (which)) Date thereof Nov 6-47 (month) (day) (year)

Cemetery or crematory: Stevensville

Location: Stevensville Md

18. Funeral director: Edgar L Lane

Address: Church Hill Md

19. Nov 7 1947 (Date rec'd by registrar) Elizabeth Hopkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1947 at 2 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 4 1947 to Nov. 4 1947

and that I last saw him alive on Nov. 4 1947.

Immediate cause of death	DURATION
Coronary occlusion	Nov 4 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Theodor Bittelmeier M.D. M. D. or other

Address: Stevensville Date signed 11/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 13 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10318

CERTIFICATE OF DEATH

Reg. Dist. No. 21-3

1. PLACE OF DEATH:
County Queen Anne's
City or town Chester (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Queen Anne's
City or town Chester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Madeline Deborah Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife James Hugh Harris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 2 - 1868

8. AGE: Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace Queen Anne Co (Town, county, and state)
10. Usual occupation
11. Industry or business Home Wife

FATHER
12. Name William G. Timms
13. Birthplace Md

MOTHER
14. Maiden name Amanda Dagg
15. Birthplace Md

16. Informant Mrs Crowe Lewis
Address Love Point Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 30-47 (month) (day) (year)
Cemetery or crematory Stevensville
Location Stevensville Md
18. Funeral director Edgar L Lane
Address Church Hill Md

19. Nov. 30 1947 (Date rec'd by registrar) Elizabeth Foster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947 at 2 55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1937 to Nov. 27 1947
and that I last saw h Ca alive on November 26 1947

Immediate cause of death	DURATION
Tuberculosis of lungs	about 9 years
Due to Pleurisy following Influenza	1937
Due to	
Other conditions Arterial regurgitation	1942

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmaier M.D.
M. D. of other
Address Stevensville Date signed Nov. 27, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 4 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 10321

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Ms. Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queenanne
City or town: Wright's Neck
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 3 Box 135
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James H. Miller Sr
3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	Married

6.(b) Name of husband or wife: Lillie L. Miller
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Jan. 1 1871

8. AGE:

Years	Months	Days	If less than one day
76	10	13	...hrs. ...min.

9. Birthplace: Queen Anne's Co.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: George Clayton
13. Birthplace: Queen Anne's Co.
MOTHER 14. Maiden name: Harbutta Miller
15. Birthplace: Queenanne Co.
16. Informant: Lillie L. Miller
Address: Wright Neck
17. Burial, cremation, or removal. Which?: Burial Date thereof: 11/15-47 (month) (day) (year)
Cemetery or crematory: Centreville Md.
Location: Queenanne Co.
18. Funeral director: Leon W. Henry
Address: 310 South St. Easton Md.
19. 11-14- 1947 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 13. 1947 at 5.35 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 13. 1947 to Nov 13 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Chronic Interstitial Nephritis	2
Due to with Heart complication	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. Henry Frabier M. D. or other
Address: Centreville Md Date signed: 11/14-47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 28 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

48a 10319

CERTIFICATE OF DEATH

Reg. Dist. No. 252

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Centreville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Leona Morris

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Morris
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 15 - 1895

8. AGE:

Years	Months	Days	If less than one day
52	3	13	..... hrs. ..... min.

9. Birthplace: Caroline Co - Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Morris
13. Birthplace: I do not know

MOTHER
14. Maiden name: Ida Roe
15. Birthplace: Queenstown - Md

16. Informant: My Carl Morris
Address: Centreville, Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Nov 30/47 (month) (day) (year)
Cemetery or crematory: Chesterfield Cemetery
Location: Centreville, Md
18. Funeral director: Butts Bros
Address: Centreville, Md

19. 11-29-1947 (Date rec'd by registrar) Elsie Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1947, at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1947, to Nov 28 1947
and that I last saw h.er alive on Nov 26 1947

	DURATION
Immediate cause of death	
Generalized Carcinomatosis	3 mo
Due to: Carcinoma of Cervix	9 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Cervix
Date of op. May 15, 1947
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: C K Lee M. D. or other
Address: Centreville Md Date signed 11-29-47

RECEIVED
DEC 3 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10321

1626

Reg. Dist. No. 251

1. PLACE OF DEATH:
County: Q A Co
City or town: Ludlowville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne's
City or town: Sudlersville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ....
(If rural, give LOCATION)
2.(a) If veteran, name war ....

3.(a) FULL NAME: Joseph Arthur Stafford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Lydia Anne Stafford
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March 14, 1855

8. AGE: Years	Months	Days	If less than one day
92	8	3	....hrs. ....min.

9. Birthplace: Q A Co (Town, county, and state)
10. Usual occupation: Shoemaker
11. Industry or business: Retired

FATHER
12. Name: John Stafford
13. Birthplace: Q A Co

MOTHER
14. Maiden name: Harriet Robey
15. Birthplace: Q A Co

16. Informant: Mrs Grace Hutchins
Address: 59 Person Ave, Verona N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 20 1947 (month) (day) (year)
Cemetery or crematory: Sudlersville
Location: Sudlersville Md

18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. Nov. 20 1947 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1947 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to Nov 17 1947 and that I last saw him alive on Nov 16 1947

Immediate cause of death	DURATION
Senility	
Due to: General Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. ....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: C H Metcalfe M. D. or other
Address: Ludlowville, Md Date signed 11/20/47

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 9 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46e

10322

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: P G

City or town: Lothurville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Practically all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: P.G.

City or town: Sudersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Yarman Starkey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Mary Edna Starkey

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Oct 24 1884

8. AGE: Years	Months	Days	If less than one day
63	0	29	...hrs. ...min.

9. Birthplace: Md Bayday (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER — 12. Name: Chas W. Starkey

13. Birthplace: P G

MOTHER — 14. Maiden name: Edna Wickersham

15. Birthplace: P G

16. Informant: Mary Edna Starkey

Address: Lothurville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-47 (month) (day) (year)

Cemetery or crematory: Sudersville

Location: Sudersville Md

18. Funeral director: Edgar L. Lowe

Address: Church Hill Md

19. 11-27 1947 (Date rec'd by registrar) Edgar L. Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1947 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1946 to Nov 23 1947 and that I last saw h... alive on Nov 23 1947

Immediate cause of death	DURATION
Cancerous growth of Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: C N Ufticille M. D. or other

Address: Lothurville Md Date signed 11/27/47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

10323

Reg. Dist. No. 254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V.S. A15 9-45-15M

1. PLACE OF DEATH:

County: Queen Anne's

City or town: Rural Pondtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Queen Anne's

City or town: Rural Pondtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Taylor

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	married

6.(b) Name of husband or wife: Herman Taylor

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: about 75 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Fannie Jones

MOTHER — 15. Birthplace: Virginia

16. Informant: Herman Taylor

Address: Sudlersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 27 1947 (month) (day) (year)

Cemetery or crematory: Bethel Cem.

Location: Rural Pondtown Md.

18. Funeral director: Edward Tydeliver

Address: Millington Md.

19. 11-26 1947 (Date rec'd by registrar) Edgar L. Kane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 23 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 to Nov 23 1947 and that I last saw him alive on Nov 22 1947

Immediate cause of death	DURATION
Coronary Occlusive Dilatation	
Due to: Chronic Myocarditis	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: C. M. Whitcraft M. D. or other

Address: Preston Md Date signed: 11/30/47

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DEC 9 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92 b

10324

CERTIFICATE OF DEATH

Reg. Diat. No. 253

1. PLACE OF DEATH:
County: Queen Annes
City or town: Chester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Annes
City or town: Chester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Eugene Thompson

3.(b) Social Security Number: 214-20-4942

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mary Lavinia Thompson
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 6 - 1871

8. AGE: Years	Months	Days	If less than one day
76	7	9	..... hrs. ..... min.

9. Birthplace: Chester, Q.A.Co., Maryland
(Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business

FATHER
12. Name: Alexander Thompson
13. Birthplace: Kent Island, Q.A.Co. Md

MOTHER
14. Maiden name: Julia Legg
15. Birthplace: Kent Island Q.A.Co. Md

16. Informant: Roland Thompson
Address: Betterton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 17-47 (month) (day) (year)
Cemetery or crematory: Stevensville
Location: Stevensville, Maryland

18. Funeral director: Baker Bros
Address: Centreville, Maryland

19. Nov. 17 1947 (Date rec'd by registrar) Elizabeth Porter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15 19 47, at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from (May 1) 19 46 to (Novemb 15) 19 47.
and that I last saw h... alive on (November 14) 19 47

Immediate cause of death: Arterio Sclerosis (general)

DURATION: several years

Due to: Sclerosis of Coronary arteries — about 2 years

Due to: myocardial degeneration

Due to: mitral regurgitation — Nov. 12. 1947.

Due to: cerebral thrombosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Theodor Sattelmeier M.D.
M. D. or other
Address: Stevensville Date signed: Nov. 15. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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NOV 20 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92a 10325

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County: Queen Anne's

City or town: ~~Chester~~ Love Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Q. A. 2nd

City or town: ~~Chester~~ Love Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Olin Thompson | **3.(b) Social Security Number**

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Eva Thompson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 16 - 1888

8. AGE: Years: 59 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Retired Railroad worker

11. Industry or business

FATHER — 12. Name: William W. Thompson

13. Birthplace: Q. A. Co

MOTHER — 14. Maiden name: Emily Clendaniel

15. Birthplace: Md

16. Informant: Wm. H. Thompson

Address: Love Point

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 24-47 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: Balt Md

18. Funeral director: Clifton J. Lane

Address: Church Hill

19. Nov 23 1947 (Date rec'd by registrar) Elizabeth Hafter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22 1947 at 10 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 22 1947.

and that I last saw him alive on Nov. 21 1947.

	DURATION
Immediate cause of death: coronary thrombosis	Nov 22 1947
Due to: auricular fibrillation	about one year
Due to: Aortic stenosis, hypertrophy and dilatation	several years
Due to: Arteriosclerosis	years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Theodor Sattelmaier M.D.

Address: Stevensville Date signed: Nov. 22 1947 M.D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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NOV 29 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 10326

Reg. Diat. No. 254

1. PLACE OF DEATH:

County: Queen Anne

City or town: Rural Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Rural Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James Thomas Usilton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Margaret Ann Usilton

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 31, 1872

8. AGE:

Years	Months	Days	If less than one day
75	7	16	..... hrs. ..... min.

9. Birthplace: Talbot County, Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Oyster and Fish

FATHER

12. Name: James Harrison Usilton

13. Birthplace

MOTHER

14. Maiden name: Emily Clanahan

15. Birthplace: Centreville, Md.

16. Informant: Mrs. Margaret England

Address: Queenstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 20-47 (month) (day) (year)

Cemetery or crematory: Crumpton

Location: Crumpton Md

18. Funeral director: Edgar L Lane

Address: Church Hill, Md

19. 11-18-47 (Date rec'd by registrar) Helen M. Aldridge Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17 1947 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1946, to November 1947

and that I last saw him alive on November 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arterio sclerotic Cardiovascular Disease	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William C. Lane, MD M. D. or other

Address: Queenstown, MD Date signed 11-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 24 1947
BUREAU OF S

To be filed in November. Orig. cert. in July deaths.

No. Punched - July Cert.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County QUEEN ANNE

City or town RURAL STEVENSVILLE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County QUEEN ANNE

City or town GRASONVILLE

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war NO

3. (a) FULL NAME JAMES ARTHUR WILLIAMS

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	MARRIED

6.(b) Name of husband or wife LOUISE JOHNSON

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MAY 13, 1905

8. AGE: Years	Months	Days	If less than one day
42			..... hrs. ..... min.

9. Birthplace GRASONVILLE, MARYLAND (Town, county, and state)

10. Usual occupation FARMER

11. Industry or business DAY LABORER

FATHER 12. Name RICHARD WILLIAMS

13. Birthplace GRASONVILLE, MD.

MOTHER 14. Maiden name BESSIE WILSON

15. Birthplace GRASONSVILLE, MD.

16. Informant PERCY WILLIAMS

Address GRASONVILLE, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11/19/47 (month) (day) (year)

Cemetery or crematory GRASONVILLE,

Location GRASONVILLE, MD.

18. Funeral director BARTON BROS.

Address CENTREVILLE, MD.

Nov. 20, 1947 (Date rec'd by registrar) Eliz. Hopter Registrar

MEDICAL CERTIFICATION

Body found

20. DATE OF DEATH NOV. ..... 19 47, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
His bones were found in a field on	
Due to farm near Matepeake, Md.	
He has been missing since July 12, 1947, he	
Due to was identified from clothing found at the	
spot by his brother.	
Other conditions Death was probably due to exposure	
and Malnutrition.	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Henry Fisher M. D. or other

Address Centreville, Md. Ex. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M